TDMHMR Mental Health Resiliency and Disease Management
Fidelity Toolkit – September 2006
II.C Adult Mental Health Programs – Cognitive Behavioral Therapy (CBT) for the Treatment of Depression

Note: The format of this guide has been adapted from the fidelity assessment manuals of the national EBP Toolkit Project (Drake et al).

This document is intended to be a guide for administering the CBT Fidelity Scale. In this document you will find:

I. **Introduction**: This section provides a brief overview of the cognitive behavioral therapy model, as well as an overview of the CBT Fidelity Scale.
II. **Protocol**: This section provides descriptions and scoring guidance for each of the fidelity scale items, including:
- A definition and rationale for each item.
- A list of data sources that are most appropriate for assessing the items (e.g., medical record, consumer interview, etc.)
- Decision rules to help you correctly score the item.

III. **Scoring Sheet**: A form is provided to summarize the fidelity item ratings and derive a total score. Total score ranges associated with optimal (or excellent), acceptable (or good), and unacceptable (not consistent with CBT criteria) implementation of the program are provided to assist with interpretation of total scores. The Scoring Sheet also serves as the summary form for documenting background information about the program undergoing the assessment. This program information provides a context for the ratings and can be useful in interpreting the score for the site and comparing scores of multiple sites.

INTRODUCTION

Overview of Cognitive Behavioral Therapy for the Treatment of Depression

Cognitive Behavioral Therapy is a brief, structured therapeutic treatment approach in which consumers are taught strategies to recognize and alter dysfunctional thinking patterns and behaviors and to solve current problems. The model emphasizes collaboration between the therapist and consumer to decide what to work on in a session, how often to meet, and what practice or homework the consumer should work on. Cognitive behavioral therapy is primarily focused on the here and now, but may include work on historical events when clinically indicated. Cognitive behavioral therapy emphasizes active, concrete tasks and practice to enhance the learning of skills and generalization outside of the therapy context. The cognitive behavioral approach that will be emphasized in the DSHS system is Cognitive Therapy, originally described by Beck, Rush, Shaw, and Emery (1979).

Overview of the CBT Fidelity Scale

The CBT Fidelity Scale aims to identify the key elements of CBT necessary for successful implementation. The scale has been based primarily on the Cognitive Therapy Rating Scale (Vallis, Shaw, & Dobson, 1986), which is a validated measure of therapist competency in the provision of Cognitive Therapy. To selected areas of the CTRS, organizational components that ensure staff competency and support have been added. In addition, items have been added to ascertain whether core skills and techniques are being used across the course of therapy. The scale contains three items pertaining to system supports for the practice, four items addressing key therapeutic processes, and 6 items pertaining to the core skills and change techniques used in the course of therapy, for a total of 13 items. Items are rated on a 5-point rating scale ranging from "1" (indicating that the program element is not implemented) to "5" (indicating that the program element is fully implemented). A score of "3" on an individual item indicates minimally acceptable implementation. The standards incorporated in the anchor descriptions for each item were based upon evidence, ethical principles, or the "expert consensus" of the fidelity assessment development group.

Rapid Review Process

Some of the elements, designated by gray fill on the Fidelity Instrument, are items to be reviewed as a part of the Rapid Review process. The Rapid Review process has been developed to serve as both a readiness measure and to ensure that critical structural elements remain in compliance on an ongoing basis. Unlike fidelity reviews where a variety of data collection methods are used, the majority of the Rapid Review elements are scored by conducting interviews with administrative and provider staff, Human Resource records, and a checklist. Interviews may be done in person or by phone. The Rapid Review rating scales will

consist of "Yes" for current practice or "No" for not evident, the five point likert-type scale will not be used. The results are used both internally and externally to monitor structural adherence to the service model. The Rapid Review process may involve different elements over time, allowing for a more complete picture of service fidelity.

References

Beck, A.T., Rush, A.J., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Vallis, T.M., Shaw, B.F., & Dobson, K.S. (1986). The Cognitive Therapy Scale: Psychometric properties. *Journal of Consulting and Clinical Psychology, 54,* 381-385.

General (Cross-item) Definitions

Consumers refer to adults (18 or older) in the DSHS priority population receiving psychotherapy services provided by or contracted by the site.
Therapists refers to site staff members with clinical experience and education in the provision of psychotherapy who enter into a role of therapist with consumers.

If consumers receive psychotherapy through a community referral to a therapist who is not employed by the site, not reimbursed by the site, and sessions are not billed by the site nor documented in encounter databases, these community therapists should not be included in the fidelity assessment.

General Assessment Issues

A comprehensive, complete assessment of fidelity generally involves collecting data from various sources. The fidelity manual provides a description of reasonable sources of information to assess the item. It may be reasonable, given the purpose of the assessment and resource limitations, to restrict the assessment of fidelity to only one source of data. Similarly, the assessment may be limited to only certain components of the scale. An assessment may be designed to target components that are easier to implement, easier to assess, or provide structure for the development of other components. When interpreting the results of the fidelity assessment, the limitations resulting from these modifications should be noted.

A common issue that may arise in fidelity assessment is the likelihood that a substantial percentage of consumers may withdraw or terminate treatment prior to the end of the recommended course. This will impact fidelity on items that are judged over the course of treatment, such as introduction of schemas or relapse prevention. A guideline that delineates when an item should be scored in the event a consumer has terminated from treatment follows:

Item Number	Number of Sessions Reached if to be Scored
Item 8: Identifying Automatic Thoughts	2
Item 9: Interventions to Challenge Automatic Thoughts	4
Item 10: Behavioral Interventions	5
Item 11: Problem Solving Skills	5
Item 12: Identifying and Modifying Schemas	12
Item 13: Preparation for Termination & Relapse Prevention	16 (or evidence of planned termination)

System Support for CBT (Items 1-3)

General Rationale: Experience with CBT implementation efforts and the knowledge base on organizational change suggest that certain program supports are necessary for successful implementation of this type of intervention.

Item 1: Therapist Credentials

Definition: Therapists providing cognitive behavioral therapy for adults are LPHAs or have a master's degree in a human services field and practice under the supervision of an LPHA. For purposes of definition, "human services field" is defined as a master's degree that can lead to licensure as an LPHA.
Rationale: Providers of psychotherapy need to have met minimum requirements to practice within the scope of the appropriate licensing board. In addition, trainees may conduct psychotherapy under the supervision of a licensed practitioner. Minimum requirements for staff credentials ensure services are provided in a manner that is consistent with basic clinical and ethical standards of the field.

Sources of Information: Human resource records; documentation provided by therapists. Licensed staff should display their license in a conspicuous place.
Item Scoring: This item may be answered 1 or 5 only. The reviewer should answer 5 if 100% of all therapists providing cognitive behavioral therapy to adults are LPHA's or have a master's degree that can lead to licensure as an LPHA and are under supervision by an LPHA. If any therapists do not meet these credentials, the reviewer will score a 1.

To determine if a trainee is receiving supervision by an LPHA, the reviewer may look for a signature on progress notes, documentation of supervision hours, or interview of the clinical supervisor.

Item 2: Training: Didactic and Experiential Course
Definition: Therapists have satisfactorily completed a state-approved training program in cognitive therapy for adults with depression.
Rationale: In order to ensure consistency in training levels and a minimum knowledge base, all providers should receive training in cognitive behavioral conceptualization, techniques, and interventions.
Source: HR training records
Item Scoring: This item may be answered 1 or 5 only. The reviewer will answer 5 if the training records indicate 100% of therapists have been trained in a state approved Cognitive Behavioral Therapy (CBT) program. Training records must indicate that the provider participated in all of the training, and list the name of the trainer and dates of training. If any therapist conducting CBT for the site has not been trained, the answer is 1.

Item 3: Training: Supervision
Definition: After completion of the training course in cognitive behavioral therapy, therapists are supervised either individually or in a group by a supervisor skilled in CBT until competency is reached. Sites should have a documented process to assess therapist competency in the provision of cognitive behavioral therapy.
Rationale: Training in CBT requires continued development of skills during actual therapy sessions with consumers. Competency is unlikely to be reached by most therapists through didactic and experiential coursework alone. The development of new therapy skills will be enhanced by monitoring and feedback by a skilled clinical supervisor.
Source: Training records; supervision records; interview of clinical supervisor.
Item Scoring: To score this item, reviewers should look for two criteria. First, the reviewer will look for whether the agency has defined procedures for assessing the competency of therapists to provide CBT to adults with depression and determine if these procedures are clear and objective. Second, the reviewer will look to see the frequency at which the supervision is provided to therapists. Therapists who are not receiving supervision should have documentation that they were assessed and judged competent to provide the service without supervision according to the agency's policies. The supervision frequency criteria may be scored as met if therapists generally receive supervision at the specified frequency, even if the criteria is not met during every time period (week, month, etc.). Agencies must meet both criteria (policies on competency and supervision frequency) within an anchor to receive that score. If only one criteria is met, the lower score should be evaluated to determine if it is met.

CBT Therapeutic Process (Items 4-7)

General Rationale: In addition to the vital interpersonal skills required for any effective therapeutic relationship (warmth, empathy, unconditional positive regard), provision of CBT involves specific therapeutic behaviors aimed at effectively using time in a brief therapy approach, creating an active, collaborative therapy process, and increasing generalization of the use of skills outside of therapy.

Item 4: Structured and Agenda Directed Sessions
Definition: The CBT therapist collaborates with the consumer to develop an agenda for the session. The therapist uses the agreed upon agenda to address key issues or skills development. The therapist effectively manages time by directing the consumer back to agenda items or renegotiating agenda items when necessary. The therapist and consumer may collaboratively choose to address a different issue that arises and use the agenda flexibly to make progress towards therapeutic goals.
Rationale: CBT is an active, time-limited treatment. The session agenda serves to set the collaborative tone of the therapy, with the consumer gradually taking more responsibility over the issues discussed in treatment. The agenda provides a consistent structure to therapy, increasing consumers' comfort and

understanding of the therapy process. Because of the time-limited nature of CBT, the therapist must effectively manage time during sessions in order for consumers to maximize their experience.
Source: Observation, chart reviews, consumer interviews, supervision notes
Item Scoring: Towards the beginning of each session, the therapist should develop an agenda with the consumer. The agenda should include activities that repeat at each session, such as a mood check, review of homework assignments, and setting homework at the end of sessions. In addition, the agenda should include issues that the consumer would like to address and may include skills that the therapist plans to work with the client on. Merely asking if there is anything the consumer would like to discuss does not qualify as setting an agenda. The therapist should effectively manage time so that reasonable progress on agenda items should be made. Observation or documentation should demonstrate that the therapist is able to address most items on the agenda. Occasionally, an issue may arise that is not on the agenda that either the consumer or therapist would like to address and the agenda may be renegotiated. Each session is judged independently on the use of an agenda and effective use of time.

Item 5: Guided Discovery
Definition: The CBT therapist uses exploration, information seeking, and questions to assist the consumer in exploring the validity of automatic thoughts, recognize faulty logic, explore alternative perspectives, and to reach balanced, reality-based conclusions following this exploration. The process of guided discovery is in contrast to the therapist that lectures, debates, or attempts to argue the consumer out of a position. The skillful use of guided discovery will result in the consumer feeling a sense of awareness, but not manipulated or critiqued.
Rationale: Consumers often accept new perspectives more readily when they reach their own conclusions than when the therapist tries to debate with the consumer (Young & Beck, 1980). Skillfully phrased questions can lead the consumer to recognize problematic thinking or behaviors and avoid placing the consumer in the position of defending the maladaptive thoughts or behaviors.
Source: Observation through audio or videotapes. This important skill is less apparent to the consumer in therapy than other processes and is unlikely to be assessed well through consumer interview.
Item Scoring: This item should be assessed based on a review of the therapist's techniques. For the criteria to be met for an individual session, the therapist must predominantly lead the consumer to explore other perspectives, recognize the problems with their own thinking, or draw their own conclusions using open-ended questions or instructions. If the therapist predominantly lectures, debates, argues or otherwise tries to persuade the consumer, the session would not meet criteria for this item. Likewise, if the therapist provides little to no guidance to the consumer to help him or her reach reasonable conclusions, relies solely on reflection, summarization, and other active listening strategies than the session would not meet the criteria for this item.

Item 6: Therapist Seeks Feedback
Definition: The CBT therapist seeks explicit statements from the client about his or her understanding and perception of the therapy process itself, and to gauge whether there is reciprocal understanding or clarity between the therapist and client. The therapist may seek feedback following the explanation of a topic or skill, during shifts in affect, following summarization of activities or topics, at the end of sessions, or at other appropriate moments.
Rationale: Feedback seeks to garner (a) a therapeutic working relationship, including rapport, (b) consensus on goals and treatment procedure, (c) collaboration in defining and "solving" problems, (d) an understanding of counterproductive thoughts and reactions to the therapy, stumbling blocks in therapy, progress toward goals, etc. The therapist uses feedback from the client to modify educational or therapeutic techniques and involve the client in identifying the most helpful techniques for them.
Source: Observation, chart reviews, consumer interviews, supervision notes
Item Scoring: This item may be assessed based on the therapist's asking the consumer for feedback, asking questions to ensure patient's understanding of topics or satisfaction with therapy, asking the consumer to summarize main points, and responding to unsolicited verbal or non-verbal feedback provided by the consumer. For the criteria to be met for an individual session, the therapist needs to elicit feedback at several points in the therapy session, asking enough questions to assess consumer understanding of the skills or issues discussed and consumer reaction to the therapy session itself.

Item 7: Home Exercises
Definition: Therapist consistently (a) suggests activities or exercises for the client to do at home which build on the work being done in therapy, and which furthers the client's skills or self-understanding, and (b) reviews previous home assignments to ensure success and learning. As therapy progresses, the therapist may rely on the consumer to identify home exercises, but this should still be agreed upon in a therapy session.

Rationale: Activities outside of the session serve several purposes. Through home exercises, the consumer is strongly encouraged to continue "therapy" outside of the session. The exercises are aimed at continuing and/or maintaining progress between sessions, seeking additional data on depressive thoughts, feelings, and behavior, testing hypotheses, practicing new skills in natural environment, and helping consumers work to become their own therapist following treatment. Research has found that patients who carry out home assignments progress better in therapy than those who do not (Neimeyer & Feixas, 1990; Persons, et al., 1988).
Source: Observation through audio or videotapes, chart reviews, or consumer interviews.
Item Scoring: For each session reviewed, the reviewer must judge that both appropriate homework assignments are made and previous homework assignments are discussed. Appropriate homework assignments should be relevant to issues discussed in the session, be consistent with cognitive behavioral therapy, and be adequately explained. Discussion of previous home assignments should include a discussion of whether the consumer was able to complete the assignment, feedback from the client on the effect of the exercise, identification of barriers and problem solving if assignment was not fully completed. Failing to assign home exercises in a given session may be acceptable if the consumer and therapist collaboratively reach this decision. This may be necessary to maintain rapport or for other clinical reasons; however it should not be a regular occurrence.

Use of Cognitive and Behavioral Therapeutic Techniques (Items 8-13)

General Rationale: The aim of CBT is to reduce the symptoms of depression and improve functioning. This is done by changing thoughts and schemas, mood, and behavior. A variety of strategies may be used to achieve therapy goals, with the choice of strategies based on the therapist's understanding of the consumer's unique issues and style, the stage of therapy, and the target of the therapeutic technique.

Item 8: Identifying Automatic Thoughts

Definition: The CBT therapist explains automatic thoughts to clients and teaches them how to recognize and "catch" automatic thoughts. Automatic thoughts are defined as cognitions or images that arise for an individual without deliberate focus. They are sometimes described as thoughts that "pop into your head."
Rationale: The cognitive model states that interpretations of a situation, rather than the situation itself, influence one's subsequent affect and behavior. A core strategy of CBT is to identify thinking patterns that lead a consumer' negative affect and/or depressogenic behavior. For a consumer to be able to challenge or change these negative thinking patterns, he or she must be able to recognize these thoughts as they occur.
Source: Chart reviews, consumer interviews, supervision notes (observation is a possible source but would require observation of the full course of therapy).
Item Scoring: This item is scored for each consumer in the sample. If sources indicate that the therapist explained automatic thoughts to the consumer and taught them to recognize such thoughts during at least one session, the record can be scored as having met this criteria. Evidence for teaching strategies to identify automatic thoughts would include the use of a thought record, homework assignments, use of a worksheet on identifying automatic thoughts, use of the Automatic Thought Questionnaire, use of a worksheet on thinking errors. The therapist may teach the consumer a series of questions he/she may ask to identify automatic thoughts.

Item 9: Interventions to Challenge Automatic Thoughts

Definition: The CBT therapist works with consumers to evaluate automatic thoughts. The therapist works to make incremental changes in the consumer's belief in key cognitions and strives to teach the consumer skills to self-examine their thoughts. Techniques should be appropriate for the problem and be explained so that they seem sensible to the consumer.
Rationale: Cognitive strategies and interventions assist the client in being able to identify and monitor negative automatic thoughts; recognize the connection between cognition, feelings and behavior; examine evidence for and against distorted automatic thoughts; and substitute more reality-oriented interpretations for biased thoughts. It is a key tenet of the cognitive model that replacing dysfunctional thoughts will result in more adaptive feelings and behaviors.
Source: Chart reviews, consumer interviews, supervision notes (observation is a possible source but would require observation of the full course of therapy).
Item Scoring: This item is scored for each consumer in the sample. If sources indicate that the therapist has worked with the consumer on a least two different cognitive strategies to examine and potentially change dysfunctional automatic thoughts during the course of therapy, the record can be scored as having met this criteria. Evidence for teaching strategies to evaluate automatic thoughts include:

- evaluating the evidence for and against a thought
- generating alternative explanations for an event
- identifying the advantages and disadvantages of keeping versus changing a thought

- thought stopping
- thought replacement
- cognitive continuum to address absolute thinking
- conducting experiments to test validity of thoughts
- coping cards that identify an adaptive response to a common automatic thought
- cognitive rehearsal of a distressing event.

Other techniques may also be acceptable.

Item 10: Behavioral Interventions

Definition: The CBT therapist uses behavioral interventions to address thoughts or behaviors that are distressing or contributing to symptoms of depression. Behavioral interventions utilize strategies to change behavior, including reinforcement and/or punishment, teaching of behavioral skills (e.g., relaxation, assertiveness training), or incorporating adaptive coping skills, among other things. Techniques should be appropriate for the problem and be explained so that they seem sensible to the consumer.

Rationale: Behavioral interventions assist the client in developing adaptive skills or behaviors, address behavioral deficits, and aim to overcome motivational or energy barriers that are associated with depression. Behavioral interventions are frequently concrete, easy to understand, and provide a successful experience early in therapy.

Source: Chart reviews, consumer interviews, supervision notes (observation is a possible source but would require observation of the full course of therapy).

Item Scoring: This item is scored for each consumer in the sample. If sources indicate that the therapist has worked with the consumer on a least one behavioral strategy to change maladaptive behaviors or incorporate new adaptive behaviors during the course of therapy, the record can be scored as having met this criteria.

Examples of behavioral techniques and interventions include:

- activity monitoring and scheduling
- accomplishment and pleasure ratings
- graded task assignment
- task prioritization
- relaxation strategies
- behavioral contracting for treatment compliance problems
- acting as if (or “Fake it until you make it”)
- graded exposure
- response prevention
- assertiveness training
- social skills training

Item 11: Problem-Solving Skills

Definition: The CBT therapist teaches the consumer problem-solving strategies to address issues important to the consumer. The therapist teaches a step-by-step process for identifying and solving problems and/or decision making.

Rationale: Most consumers identify one or more problems (either significant problems or daily hassles) that result in distress, negative evaluations of self, or impede adequate functioning. Frequently, the experience of depression exacerbates the problem through distorted thinking (e.g. "I can't change anything), physical inertia, or poor concentration and cognitive skills. Consumers who previously had adequate problem solving skills may now be overwhelmed by problems due to their depression. Concrete teaching and practice of problem solving skills can enhance self-efficacy, help address cognitive barriers to decision making, and provide a practical experience of success.

Source: Chart reviews, consumer interviews, supervision notes (observation is a possible source but would require observation of the full course of therapy).

Item Scoring: This item is scored for each consumer in the sample. If sources indicate that the therapist (a) taught problem-solving skills and (b) assisted the consumer in applying the process to at least one problem troubling the client, then the record can be scored as having met this criteria.

Item 12: Identifying and Modifying Schemas

Definition: The CBT therapist introduces the concept of schemas to the consumer and engages in one or more interventions aimed at modifying a primary schema. The goal of interventions is the development of a new schema that is somewhat more positive and adaptive than the previous negative schema. Schemas are defined as a consumer's core beliefs, which characterize how he/she views him/herself, other people, and the world. Negative schemas may remain dormant until activated by psychological distress or be exacerbated during such times.

Rationale: Schemas are the over generalized beliefs that spark specific negative automatic thoughts. Through challenging and modifying key schemas, therapists and consumers can reduce depression, reduce the chances of relapse, and provide a technique for prevention of relapse. Although some consumers will require more time on behavioral interventions and strategies to challenge automatic thoughts, the majority of clients should at least begin to address one or more key schemas in the course of therapy.

Source: Chart reviews, consumer interviews, supervision notes (observation is a possible source but would require observation of the full course of therapy).

Item Scoring: This item is scored for each consumer in the sample. If sources indicate that the therapist (a) discussed the concept of schemas or core beliefs, generally in response to a consumer presenting a schema and (b) engaged in at least one intervention aimed at evaluating and modifying negative core beliefs, then the record can be scored as having met this criteria. Types of interventions include:

- Evidence for and against schemas
- Advantages and disadvantages for keeping schemas
- Re-examining historical evidence for and against schemas
- Cognitive continuum
- Using extreme contrasts to identify absolutist thinking
- Developing metaphors to look at a situation differently
- Restructuring early memories
- Other techniques described under Item 8.

Item 13: Preparation for Termination & Relapse Prevention

Definition: The CBT therapist discusses termination and prepares the client to use the skills taught within therapy after termination. The goal of these activities should be a consolidation of learning and preparation of the client to independently respond to future events, stressors, or thoughts that may be precursors to relapse.

Rationale: Preparations for termination and prevention of relapse activities are key tasks to assist consumers in consolidating treatment gains and incorporating newly gained skills into their lives. Although preparation for termination occurs from the very first session, discussions around termination and relapse prevention in the final sessions of therapy are an important stage for consumers to experience.

Source: Chart reviews, consumer interviews, supervision notes (observation is a possible source but would require observation of the full course of therapy).

Item Scoring: This item is scored for each consumer in the sample. If sources indicate that the therapist prepared the consumer for termination and their need to use techniques to prevent a relapse of depression, then the record can be scored as having met this criteria. Evidence for addressing termination and relapse prevention include:

- Tapering the frequency of sessions
- Reviewing what was learned in therapy
- Psychoeducation about relapse and discussion of early signs of relapse
- Asking the consumer to create coping cards that summarize helpful techniques/skills
- Discuss plan for self-therapy sessions
- Having the consumer predict future stressful situations and identify or role play coping behaviors
- Booster sessions.

Cognitive Behavioral Therapy for the Treatment of Depression in Adults (CBT) Fidelity Scale

Element	Source	1	2	3	4	5	Notes
A. System Support for CBT Effective implementation of the CBT for adults with depression requires support and coordination from the system. This includes appropriate training of credentialed staff and supervision of clinical work until therapist competency is achieved.							
1. Therapist Credentials Therapists providing CBT are LPHAs or have a master's degree in a human services field and practice under the supervision of an LPHA.	HR records, documentation by staff	Less than 100% of therapists are LPHAs or trainee's under supervision by an LPHA.	N/A	N/A	N/A	100% of therapists are LPHAs or trainee's under supervision by an LPHA.	
2. Training: Didactic and Experiential Course Therapists have satisfactorily completed a state-approved training program in cognitive behavioral therapy for adults with depression.	HR training records	Less than 100% of therapists have completed a training course in cognitive behavioral therapy.	N/A	N/A	N/A	100% of therapists have completed a training course in cognitive behavioral therapy.	
3. Training: Supervision Therapists are supervised either individually or in a group by a supervisor skilled in CBT until competency is reached. Sites should have a documented process to assess therapist competency in the provision of cognitive behavioral therapy.	Training records; supervision records; interview of clinical supervisor	Therapists do not receive supervision following training and there is some or no documentation of a process for assessing competency.	Therapists receive supervision only occasionally or upon request and there is some or no documentation of a process for assessing competency.	Therapists receive at least 1 hour per month of supervision and there is some documentation of a process for assessing competency.	Therapists receive at least 1 hour per month of supervision and there is a clearly documented process for assessing competency.	Therapists receive at least 1 hour per week of supervision and there is a clearly documented process for assessing competency.	Note: This item may not be able to be fully accomplished until adequate expertise in CBT is developed within the system.
B. CBT Therapeutic Process In addition to the vital interpersonal skills required for any effective therapeutic relationship (warmth, empathy, unconditional positive regard), provision of CBT involves specific therapeutic behaviors aimed at effectively using time in a brief therapy approach, creating an active, collaborative therapy process, and increasing generalization of the use of skills outside of therapy.							
4. Structured and Agenda Directed Sessions The CBT therapist: • Collaborates with the consumer to develop an agenda for each session • Effectively manages time within sessions.	Observation, chart reviews, consumer interviews, supervision notes	In less than 50% of sessions, the therapist works with the consumer to set an agenda and manages time effectively.	In 50% to 69% of sessions, the therapist works with the consumer to set an agenda and manages time effectively.	In 70% to 79% of sessions, the therapist works with the consumer to set an agenda and manages time effectively.	80% to 89% of sessions, the therapist works with the consumer to set an agenda and manages time effectively.	In 90% to 100% of sessions, the therapist works with the consumer to set an agenda and manages time effectively.	
5. Guided Discovery The CBT therapist uses exploration, information seeking, and questions to assist the consumer in exploring the validity of automatic thoughts, recognize faulty logic, explore alternative perspectives, and to reach	Observation, supervision notes	In less than 50% of sessions, the therapist uses guided discovery to assist a consumer in reaching more	In 50% to 69% of sessions, the therapist uses guided discovery to assist a consumer in reaching more	In 70% to 79% of sessions, the therapist uses guided discovery to assist a consumer in reaching more	80% to 89% of sessions, the therapist uses guided discovery to assist a consumer in reaching more	In 90% to 100% of sessions, the therapist uses guided discovery to assist a consumer in reaching more	Note: As this item cannot be adequately assessed without observation of a session, it may not be feasible to assess in all situations.

Element	Source	1	2	3	4	5	Notes
balanced, reality-based conclusions following this exploration. The therapist avoids lecturing, debating, or attempting to argue the consumer out of a position.		adaptive conclusions.	adaptive conclusions.	adaptive conclusions.	adaptive conclusions.	adaptive conclusions.	However, it is retained in this scale due to its importance as a key issue in CBT.
6. Therapist Seeks Feedback The CBT therapist seeks explicit statements from the client about his or her understanding and perception of the therapy process itself, and to gauge whether there is reciprocal understanding or clarity between the therapist and client.	Observation, chart reviews, consumer interviews, supervision notes	In less than 50% of sessions, therapists seek direct feedback from consumers.	In 50% to 69% of sessions, therapists seek direct feedback from consumers.	In 70% to 79% of sessions, therapists seek direct feedback from consumers.	In 80% to 89% of sessions, therapists seek direct feedback from consumers.	In 90% to 100% of sessions, therapists seek direct feedback from consumers.	
7. Home Exercises Therapist consistently (a) suggests activities or exercises for the client to do between sessions which build on the work being done in therapy, and which furthers the client's skills or self-understanding, and (b) reviews previous home assignments to ensure success and learning.	Observation, chart reviews, consumer interviews, supervision notes	In less than 50% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	In 50% to 69% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	In 70% to 79% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	In 80% to 89% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	In 90% to 100% of sessions, appropriate home activities are assigned and previous assignments are reviewed.	
C. Use of Cognitive Behavioral Therapeutic Techniques The aim of CBT is to reduce the symptoms of depression and improve functioning. This is done by changing thoughts and schemas, mood, and behavior. A variety of strategies may be used to achieve therapy goals, with the choice of strategies based on the therapist's understanding of the consumer's unique issues and style, the stage of therapy, and the target of the therapeutic technique.							
8. Identifying Automatic Thoughts The CBT therapist explains automatic thoughts to clients and teaches them how to recognize and "catch" negative automatic thoughts. Automatic thoughts are defined as cognitions or images that arise for an individual without deliberate focus.	Chart reviews, consumer interviews, supervision notes	Therapists explain automatic thoughts and taught strategies for recognizing these thoughts in less than 50% of consumers.	Therapists explain automatic thoughts and taught strategies for recognizing these thoughts in 50% to 69% of consumers.	Therapists explain automatic thoughts and taught strategies for recognizing these thoughts in 70% to 79% of consumers.	Therapists explain automatic thoughts and taught strategies for recognizing these thoughts in 80% to 89% of consumers.	Therapists explain automatic thoughts and taught strategies for recognizing these thoughts in 90% to 100% of consumers.	
9. Interventions to Challenge Automatic Thoughts The CBT therapist works with consumers to evaluate automatic thoughts. The therapist works to make incremental changes in the consumer's belief in key cognitions and strives to teach the consumer skills to self-examine their thoughts. At least two different strategies are used/taught.	Chart reviews, consumer interviews, supervision notes	Therapists teach strategies to evaluate and challenge dysfunctional thoughts in less than 50% of consumers.	Therapists teach strategies to evaluate and challenge dysfunctional thoughts in 50% to 69% of consumers.	Therapists teach strategies to evaluate and challenge dysfunctional thoughts in 70% to 79% of consumers.	Therapists teach strategies to evaluate and challenge dysfunctional thoughts in 80% to 89% of consumers.	Therapists teach strategies to evaluate and challenge dysfunctional thoughts in 90% to 100% of consumers.	
10. Behavioral Interventions The CBT therapist uses behavioral interventions to address thoughts or behaviors that are distressing or contributing to symptoms of	Chart reviews, consumer interviews, supervision notes	Therapists use behavioral interventions in less than 50% of consumers.	Therapists use behavioral interventions in 50% to 69% of consumers.	Therapists use behavioral interventions in 70% to 79% of consumers.	Therapists use behavioral interventions in 80% to 89% of consumers.	Therapists use behavioral interventions in 90% to 100% of consumers.	

Element	Source	1	2	3	4	5	Notes
depression. Behavioral interventions utilize strategies to change behavior, including reinforcement and/or punishment, teaching of behavioral skills (e.g., relaxation, assertiveness training), or incorporating adaptive coping skills, among other things. At least one strategy is taught.							
11. Problem-Solving Skills The CBT therapist teaches the consumer problem-solving strategies to address issues important to the consumer. The therapist teaches a step-by-step process for identifying and solving problems and/or decision making.	Chart reviews, consumer interviews, supervision notes	Therapists teach and assist with the practicing of problem solving skills in less than 50% of consumers.	Therapists teach and assist with the practicing of problem solving skills in 50% to 69% of consumers.	Therapists teach and assist with the practicing of problem solving skills in 70% to 79% of consumers.	Therapists teach and assist with the practicing of problem solving skills in 80% to 89% of consumers.	Therapists teach and assist with the practicing of problem solving skills in 90% to 100% of consumers.	
12. Identifying and Modifying Schemas The CBT therapist introduces the concept of schemas to the consumer and engages in one or more interventions aimed at modifying a primary schema.	Chart reviews, consumer interviews, supervision notes	Therapists discuss schemas and engage in one or more interventions to modify a schema with less than 30% of consumers.	Therapists discuss schemas and engage in one or more interventions to modify a schema with 30% to 44% of consumers.	Therapists discuss schemas and engage in one or more interventions to modify a schema with 45% to 59% of consumers.	Therapists discuss schemas and engage in one or more interventions to modify a schema with 60% to 84% of consumers.	Therapists discuss schemas and engage in one or more interventions to modify a schema with 85% to 100% of consumers.	
13. Preparation for Termination and Relapse Prevention The CBT therapist discusses termination and prepares the client to use the skills taught within therapy after termination. The goal of these activities should be a consolidation of learning and preparation of the client to independently respond to future events, stressors, or thoughts that may be precursors to relapse.	Chart reviews, consumer interviews, supervision notes	Therapists discuss termination and prepare consumers to use skills to prevent relapse with less than 50% of consumers.	Therapists discuss termination and prepare consumers to use skills to prevent relapse with 50% to 69% of consumers.	Therapists discuss termination and prepare consumers to use skills to prevent relapse with 70% to 79% of consumers.	Therapists discuss termination and prepare consumers to use skills to prevent relapse with 80% to 89% of consumers.	Therapists discuss termination and prepare consumers to use skills to prevent relapse with 90% to 100% of consumers.	